



Working Paper Series

Number 29, Autumn 2016

Providing public healthcare to irregular migrants

The everyday politics and local
negotiation of formal entitlements and
effective access in London and Barcelona

Reinhard Schweitzer

r.schweitzer@sussex.ac.uk

Grup de Recerca Interdisciplinari en Immigració - UPF
Departament de Ciències Polítiques i Socials
Universitat Pompeu Fabra
www.upf.edu/gritim
gritim@upf.edu

The purpose of the GRITIM-UPF Working Paper Series is to disseminate academic research work in progress that contributes to the European approach on immigration and diversity. The main framework is related to GRITIM UPF three main priorities: multidisciplinary, innovation, and transfer of knowledge. Its contents are related to its research areas: immigration and governance, immigration and society, immigration and law, economics of migration, immigration and the dynamics of diversity, immigration and communication and immigration and humanities. GRITIMUPF Working Papers will be published quarterly (at least one per term, four per year).

GRITIM-UPF Editorial Board:

Zenia Hellgren (coordinator)
Ricard Zapata-Barrero
Sílvia Morgades
John Palmer
Teun van Dijk
Elena Sánchez Montijano
Blanca Garcés-Mascareñas
Lorenzo Gabrielli

Publishing Editor: Núria Franco-Guillén Department of Political and Social Sciences

Further information and requests can be addressed to gritim@upf.edu Working Paper Series, as well as other information related to research on immigration can be received by subscribing at GRITIM Distribution List: www.upf.edu/gritim/distribució

Abstract

This article aims to contribute to a better understanding of local processes of policy implementation in areas that are characterised by a high level of politicisation and where decisions are underpinned by conflicting normative and functional imperatives. Based on original research data collected in London and Barcelona, it compares the formal entitlements and effective access of irregular migrants to publicly funded healthcare services provided at the local level. My analysis suggests that where the political context makes it difficult for national governments to openly justify and formalise the inclusion of unlawful residents, they tend to resort to a contradictory rhetoric and ambiguous legal frameworks. In practice, this means that the underlying conflicts have to be mediated by lower levels of government, as well as those institutions and individuals responsible for implementing this set of complex, frequently changing and often inconsistent rules and regulations.

Keywords

Irregular migrants, public healthcare, organisational logics, hypocrisy, justification, multi-level governance;

Author's biographical note

Reinhard Schweitzer is a PhD candidate (3rd year) and Marie Curie Early-Stage Research Fellow at the Department of Geography, University of Sussex, Brighton, UK, and member of the Sussex Centre for Migration Research (SCMR). His current research compares the situation of irregular migrants living in London and Barcelona, and how local authorities, public welfare systems and institutions, and individual professionals working within them, deal with migrant irregularity in their everyday practice. During his fieldwork in Barcelona, from March to October 2015, he was a visiting PhD candidate at the Universitat Pompeu Fabra and member of GRITIM.

Introduction¹

Democratic governance means that peoples' ideas and opinion are translated into formal legal frameworks and laws, which then – through (local) implementation processes – determine actual policy practice (Deutsch, 1970). Particularly in areas of policy-making that tend to be highly politicised, such as immigration, academic debate has long circled around the question of why these regulatory processes often fail to achieve the desired outcomes or declared objectives (Boswell, 2007; Castles, 2004; Freeman, 1995; Joppke, 1998; Lahav & Guiraudon, 2006; Sassen, 1996; Soysal, 1994). More specifically, scholars have identified a gap between the official aims of immigration policies – which increasingly reflect the rising public pressure to restrict further unwanted immigration – and their often more liberal outcome regarding not only the admission of foreigners to the country but also their access to various social and economic rights (Cornelius, Martin, & Hollifield, 1994; Hollifield, 1986). This article aims to contribute to this debate through a detailed analysis of the processes, arguments and actors involved in the implementation of one particular set of rules, which very well exemplifies this gap: the extension of the right to access publicly funded healthcare services to those foreigners whose very presence in the host country is deemed 'illegal'.

Facing significant numbers of irregular immigrants already living within their territory, many Western governments have resorted to measures of internal immigration control, which tend to intersect with various other strands of mainstream public policy, and particularly the welfare regime (Broeders & Engbersen, 2007; Lahav & Guiraudon, 2006; Van Der Leun, 2006). While this often means that because of their administrative status these individuals are formally excluded from many of the host state's institutions, it has been argued that in everyday practice their exclusion is almost never absolute but usually intertwined with simultaneous processes of inclusion (Chauvin & Garcés-Mascareñas, 2012; Cvajner & Sciortino, 2010; De Genova, 2013; Mezzadra, 2011). In part, this is because the responsibility to actually enforce this kind of immigration control is spread across a wide range of institutions and individuals who do not necessarily share the immigration authorities' interests and priorities (Boswell, 2007; Walsh, 2014; Webber, 2014). This is particularly evident in the area of public

¹ The research leading to these results has received funding from the European Union's Seventh Framework Programme (FP7/2007-2013) under grant agreement n° 316796.

healthcare, where powerful normative entitlements, as well as intrinsic functional logics and a particularly strong professional ethics often demand at least a certain level of access for foreign residents irrespective of their immigration status (Ambrosini, 2015; Dwyer, 2015; Hall & Perrin, 2015; Spencer, 2014). At a time of significant cuts to healthcare budgets and widespread anti-immigrant sentiments, however, institutions and individuals providing and administering public healthcare services to local residents also face a heightened pressure to differentiate between those who (medically) need and (morally) ‘deserve’ a particular treatment, and those who do not. Health reforms in both the UK and Spain have been accompanied by intense political debates around the issues of ‘health tourism’ and the presumed ‘pull effect’ (‘efecto llamada’) often attributed to an explicitly inclusive health provision (DOTW, 2013; Wind-Cowie & Wood, 2014).

In order to capture the actual difficulties that migrant irregularity entails for local health provision I focus on both the role of individual service-providers and the legal-institutional structures in which their actions and decisions are embedded. Brunsson’s (1989, 1993) contribution to organisation theory offers a promising theoretical approach that helps to explain how organisations respond to contradictory external demands and pressures by accepting and internalising certain inconsistencies between what is officially declared (‘talk’), what is put into law (‘decisions’) and what is effectively done (‘actions’). The two cases compared here suggest that depending on the broader political context, the level of politicisation and specific framing of the issue of irregular migration, governments tend to either resort to what Brunsson (1993) calls ‘justification’, as arguably is the case in Catalonia, or ‘hypocrisy’, which resembles the situation in the UK. My analysis shows that especially where decision-makers feel unable to openly justify at least a certain level of inclusion towards irregular migrants, they have to resort to a contradictory rhetoric and ambiguous legal frameworks in order to still be able to manage – at least politically – the inherent conflicts between humanitarian norms and public health concerns on the one hand, and budgetary constraints and the logic of immigration control on the other. In practice, much of the responsibility to mediate between these contradictory pressures is thereby dumped on those who implement these policies ‘on the ground’. In the following sections I will first outline the theoretical framework, then give some examples of how different political actors have been framing the issue in both cases, before taking a closer look at how the resulting legal-political frameworks shape organisational and individual action.

1. Public institutions as local mediators between conflicting functional imperatives of the state: The case of healthcare for irregular migrants

One particularly influential strand of literature trying to explain the discrepancy between officially declared policy objectives and their actual outcomes in terms of an extension of rights to non-nationals focuses on the role of (liberal) institutions (Guiraudon, 2003; Joppke, 1998). For Boswell (2007, p. 83) these approaches are based on two crucial assumptions: That institutions ‘have sufficient independence from the political system and rival administrative agencies’ and that ‘the actors within these institutions operate according to interests and norms that are at variance with those predominating politics or rival agencies’. While helpful in highlighting the fundamental role that institutions generally play in mediating policy outcomes, however, such neo-institutional approaches ‘often fail to specify the source of their resilience vis-à-vis state interests’ (Boswell, 2007, p. 76). What she therefore proposes is a theory that departs from the idea that states themselves are driven by various functional imperatives: (a) to promote a just distribution of resources (*fairness*), (b) to provide *security* for its subjects as well as (c) the necessary conditions for the *accumulation* of wealth, and (d) to respect the constitutional principles and individual liberties of those affected by its jurisdiction (*institutional legitimacy*). While each of them represents a precondition for legitimate governance, they tend to have contradictory policy implications and are therefore difficult (or even impossible) to fulfil simultaneously. Based on these premises, her refined explanation for the identified ‘gap’ between (restrictive) policy objectives and (more liberal) outcomes is that ‘a state unable to meet all functional requirements may have an interest in the persistence of contradictions and inefficiencies in policy’ (Boswell, 2007, p. 93).

What interests me here, is how these inconsistencies in policy (as well as political rhetoric) are then perceived and dealt with by those institutional and individual actors administering or providing public healthcare to local residents; to what extent they are involved in – or effectively shielded from – immigration law enforcement; and what degree of individual discretion is thereby given to different professional roles within these institutions. My analysis thus places a stronger focus on the institutional and individual levels than that of the state and thereby draws on Brunsson’s (1993, p. 489) interpretation of the possible relationships ‘between the ideas of constituencies and leaders on the one hand and organizational, and societal actions on the other’. Whereas

the conventional model of rational decision-making holds that ideas always precede and control action, he shows that this does not necessarily have to be the case where it would lead to unresolvable conflicts at the level of policy implementation. Instead, (necessary) actions can either determine ideas or be systematically inconsistent with them. Both, I will argue, is likely to be the case where irregular migrants are to be granted some form of access to public healthcare in spite of their unlawful residence.

As the basis for every human being's individual autonomy, self-fulfilment and dignity, access to health is underpinned by strong formal entitlements safeguarded through regional and international human rights instruments (da Lomba, 2011; MdM, 2014; OHCHR, 2014). At the same time, healthcare constitutes one of the core functions of the welfare state and has thus been described as an 'aspect of modern citizenship' (Aasen, Kjellefold, & Stephens, 2014, p. 162). In Boswell's (2007) terms, then, the comprehensive provision of health services – whether regarded as a basic and equal right (and thus an issue of *fairness*), or a necessary measure against potential threats to public health (and thus a question of *security*) – represents a functional imperative of the contemporary welfare state. As such, it tends to conflict with the need to control immigration, since the entitlement to access a particular state's healthcare services is underpinned by both a human and a membership right (da Lomba, 2011; Hall & Perrin, 2015). The inclusion of irregular migrants is thus not a purely humanitarian issue but also reflects their (at least partial) recognition as *de facto* members of society. Their accessing of such services could thus be argued to constitute an 'act of citizenship', which Isin (2008, p. 16) defined as 'practices of becoming claim-making subjects in and through various sites and scales'. In practice, even limited formal entitlements can create perceptions of inclusion, belonging or even a right to remain, while serious health problems or the need for a particular treatment unavailable in the country of citizenship can effectively further legal claims for regularisation and impede (or delay) deportation (Kraler, 2011; PICUM, 2009). Hence, while it is relatively easy for politicians to *declare* that those not admitted to stay should be unable to benefit from any free public healthcare provision, the idea of fully excluding them – even if popular among the public – would create significant conflicts if it was to completely control organisational action within the healthcare system. It is for such instances that Brunsson (1993) proposes two alternative (theoretical) relationships between ideas and actions, which he calls 'justification' and 'hypocrisy'. The former means that 'planned or accomplished

actions are defended in order to convince people that they are the right ones' (Brunsson, 1993, p. 500). If successful, it thus adjusts the constituency's ideas to actions, thereby restoring consistency at the expense of control (of ideas over action). For example, people may be convinced that the necessity to provide healthcare even in non-emergency cases can prevail over the need to control or limit immigration by any means. Where decision-makers find it impossible to openly justify the formal inclusion of irregular migrants, however, they have to resort to 'hypocrisy', that is, accepting inconsistencies between what is said, decided, and effectively done:

Actions that are difficult to justify can be compensated for by talk in the opposite direction. Decisions, too, can be part of hypocrisy; they can be contrary to actions, compensating for action rather than controlling or justifying it. Through hypocrisy, the ideas of the constituency are isolated from action (Brunsson, 1993, p. 501).

What according to Brunsson (1989, p. 38) theoretically links 'talk' and 'action' are 'decisions', which 'are fundamental to organisations in which politics play an important part'. When it comes to irregular migrants' access to public healthcare, politicians are supposed to decide in which cases to offer, deny, or require payment for a particular service, and do so through more or less explicit laws and regulations. But since 'drawing administrable lines that define the limits of a shared humanitarian ethic can prove difficult', as Hall and Perrin (2015, p. 132) have argued, these decisions will often ultimately depend on the medical assessment of each case by individual health professionals. Where it is decided that access is to be contingent on legal residence status it is then also on them to exercise some form of immigration control, which – while probably supported by a majority of constituents – may well contradict their own interests or organisational norms. Here, a certain ambiguity in what politicians say and decide not only increases individual actors' own discretion but thereby also makes these obvious contradictions less visible to the public: 'If decisions are ambiguous it is easier to interpret them as consistent with ideas, both when the decision is made and when the action is completed' (Brunsson, 1993, p. 499). The underlying conflict between the state's competing functional imperatives is thereby not solved but merely shifted onto the healthcare system or other implementing agencies. Before looking at how different actors then perceive and deal with these contradictory moral and legal demands, the following chapter provides a number of concrete examples for ambiguous talk and

decisions from my two case studies. The empirical sections of this paper draw on some of the material collected during my fieldwork in London (between July 2014 and February 2015) and Barcelona (from March to October 2015), including official policy documents, media reports, and a total of 19 semi-structured interviews with healthcare administrators (policy officials and reception staff), professionals (doctors and nurses), as well as representatives of NGOs and advocacy groups working in this field.

2. Between hostility and pragmatism: The ambivalent legal-political context for the local provision of public healthcare services to irregular migrants

Both in the UK and in Spain healthcare is delivered within predominantly tax-based national health systems (NHS) that were originally founded – in 1948 and 1986, respectively – on the principles of universal coverage and free and equal access (Aasen et al., 2014), but have recently undergone significant reforms and restructuring (Department of Health, 2010; Legido-Quigley et al., 2013; MdM, 2014). While mainly aiming at increasing their overall cost efficiency, these reforms also linked access rules to immigration status, and thus require the healthcare system to exercise some form of immigration control. In Spain, the national health reform of 2012² categorically excluded irregular migrants – with the exception of emergencies, minor children and pregnant women – from free public health care by invalidating their health cards (*'Tarjeta Sanitaria Individual'*, TSI) to which they had been entitled automatically and irrespective of their immigration status once registered as local residents (MdM, 2014). In March 2015, however, the Spanish minister of health announced in an interview that the central government was planning to restore the right of migrants in irregular situations to access primary healthcare services provided within the NHS. This move has become necessary, according to the minister, for a number of 'practical reasons' such as to 'avoid saturating the emergency services' that these persons otherwise tend to fall back on ("El Gobierno anuncia que devolverá parte de la atención sanitaria a los inmigrantes sin papeles," 2015). While thus recognising a certain need to provide them with *some form of access*, however, the government does not foresee irregular migrants' formal *re-inclusion* into the mainstream system. In fact, the minister made very clear

² Enacted through Royal Decree-Law 16/2012, of 20 April, on urgent measures to ensure the sustainability of the national health system and improve the quality and safety of its provisions.

that he is ‘completely against’ making them holders of the TSI, which ‘would give them a right that in Europe does not exist in any other country’ (*ibid.*).

In the UK, on the other hand, irregular migrants are currently not formally excluded from accessing free NHS primary healthcare – generally provided by local family doctors (‘General Practitioners’, GPs) – but as ‘Overseas Visitors’³ they are to be charged the full cost of accessing secondary (i.e. hospital) care (Department of Health, 2013a, 2013b). This charging regime, first introduced in 2004, has been further extended by the Immigration Act of 2014, which brings significant changes regarding many migrants’ access to healthcare. One of its main objectives is that ‘those persons who are here unlawfully should not remain and should have no entitlement to benefits or public services’ (Department of Health, 2013b, p. 27). It is also them who would most likely be affected by an eventual tightening of access to certain primary care and Accident and Emergency (A&E) services (Department of Health, 2013b; Grove-White, 2014). This declared policy goal clearly reflects the UK governments’ officially declared strategy of creating ‘a really hostile environment for illegal migration’, as expressed by Home Secretary Theresa May in May 2012 (Kirkup & Winnett, 2012). Contrary to this approach, however, then Immigration Minister Mark Harper, debating the 2014 Immigration Bill in the House of Commons (2013) Public Bill Committee in November 2013, stated the following:

I can reassure [...] that we will not do anything that will worsen public health. Of course it is important for those who are in the United Kingdom, even if they are not here legally, to have access to public health treatment, because it has an impact not just on them, but on the rest of the community.

In both cases, the ministers’ statements reflect some of the inherent contradictions between the pressure to restrict the access to these scarce public resources to ‘legitimate’ members of the community and the need for pragmatic solutions for those who *do reside* within a given locality but without the formal consent of the responsible government. In both countries the restrictive reforms have been accompanied by intense debates and critique from health professionals and civil society organisations, often highlighting the importance of universal coverage for preventing the spread of communicable diseases but also, for example, the detection of domestic violence and

³ The official category used for all foreigners who are not ‘ordinarily resident’ in the UK, including those holding tourist or visitors’ visa, as well as those residing in the country without authorisation.

abuse (MdM, 2014; semFYC, 2012). From an economic perspective, it has been argued that early and preventive treatment is cheaper than long intensive care, which often becomes necessary as a result of excluding patients from primary care (Aspinall, 2014; FRA, 2015; Steele, Stuckler, McKee, & Pollock, 2014; Wind-Cowie & Wood, 2014).

An important structural difference between both cases is that in Spain the responsibility for the provision of healthcare is devolved to the level of its 17 autonomous regions, and that the restrictions imposed by the healthcare reform of 2012 were effectively prevented through legislation enacted by several regional governments. While explicitly aiming at a better coordination and overall consistency of service provision, it thus provoked very different responses across the country (DOTW, 2013). The government of Catalonia – only four months after the entry into force of the health reform – established its own administrative norms⁴, according to which irregular migrants explicitly continue to have access to free healthcare provided and financed through the Catalan public health service *CatSalut*. The apparent disagreement between the different levels of government and the resulting contradictions between formal rules of access has contributed to a general climate of misinformation and confusion (MdM, 2014).

In the UK context, the Greater London Authority (GLA) – although not vested with comparable legal powers in the area of health but also recognising the importance of universal coverage of primary care – published a leaflet in 20 languages to raise awareness among migrants and asylum seekers and support them in registering with a GP (see fig. 1). It particularly emphasised that migrants are not legally required ‘to prove their identity or immigration status to register with a practice’ and that GPs cannot refuse registration on discriminatory grounds (Mayor of London, 2012). Launched in January 2012 as part of the Mayor’s Integration Strategy, it came as a reaction to the frequent misinterpretation of existing norms regarding (particularly irregular) migrants’ access to NHS services, and has been heavily criticized by right-wing pressure groups for further encouraging ‘health-tourism’ (Johnson, 2012). Around the same time, a poster campaign in NHS facilities specifically reminded those ‘visiting the UK, or not living here on a lawful and settled basis’ that they ‘may have to pay’ for their healthcare (see fig. 2). Arguably, both the poster’s image and text emphasise the role of NHS staff in deciding and controlling *who* has to pay, and play with irregular migrants’ uncertainty (if not fear) of being detected and apprehended as a result of

⁴ Through *Instrucción 10/2012 del CatSalut*, of 30 August 2012.

accessing public healthcare.

Figure 1



Figure 2



These examples suggest that in both contexts local institutions and healthcare workers have, at various times, received contradictory signals (even though primarily directed at the general public and/or irregular migrants themselves) and instructions regarding the relevance that a patient's immigration status should have when accessing a service they provide or administer. In the following, I thus turn to their perspectives in order to compare how the resulting policies work in everyday practice, thereby differentiating between primary and secondary care.

3. Negotiating the legal limits of access and provision: the role and agency of healthcare providers and administrators in London and Barcelona

3.1 Irregular migrants' access to primary healthcare

According to the legal frameworks currently in place, third-country nationals residing unlawfully in either London or Barcelona are formally entitled to access free primary healthcare services provided locally by family doctors and GPs. In practice, however,

they can remain effectively excluded even from this most basic provision as a result of administrative barriers, because they are not aware of their entitlement, or because they fear being reported to immigration authorities (OHCHR, 2014). Especially the latter seems to be a bigger issue in London than Barcelona, and particularly among those migrants who never had a residence permit and are not in regular contact with a support organisation. Almost 90% of the over 1500 patients received by Doctors of the World (DOTW, 2013) in London during the year 2012 were not registered with a GP and when ‘we ask people for the reasons why they haven’t been to the [regular] health service [...], like one in five say they think they will be arrested if they go and see a doctor’ (lon-A03), says Lucy Jones, the organisation’s Programme Director for the UK. In both countries, their entitlement is primarily based upon the recognition of local residence, which they have to prove by providing more or less specific documentation. In Spain this is generally done through the obligatory inscription in the municipal register (*‘padrón’*), which constitutes the primary requirement for *all* residents to benefit from any public service provided at the local level and – in the case of irregular migrants – to apply for regularisation under a mechanism called *‘arraigo social’* after three years of continuous residence. Registration is thus possible irrespective of immigration status, and migrants in irregular situation are explicitly encouraged to do so. Recognising the difficulties they often face in providing a permanent address, some local authorities, including that of Barcelona, offer them the possibility to register ‘without fixed abode’.

For irregular migrants registered in Catalonia – in contrast to most other parts of Spain – the only formal access requirements are that they declare insufficient financial resources and have been registered locally for the past three months (Ajuntament de Barcelona, 2013). Notably, this temporal limitation is justified as a necessary measure against (often intra-European) ‘health-tourism’, rather than to prevent irregular *residents* from accessing these services, as the Citizen Relations Manager of *CatSalut* explained to me in an interview conducted in June 2015 (bcn-A17). As for all residents, applications are made at the local health centre (*‘Centro de Atención Primaria’*, CAP) where applicants have to produce a document obtained from the National Institute of Social Security (INSS) certifying that they are not covered under the national system, an official confirmation of their residential registration and a copy of their passport or other ID (Ajuntament de Barcelona, 2013). Only where insufficient documentation inhibits this

standard procedure, applications are often processed through NGOs like *Salud Y Familia*, as the responsible administrator of one CAP explains:

Before, those who came without anything, without papers, were handled here. There was an application form for all those who came without papers and we processed them here. But with the new law this group has been diverted to associations that are dedicated to doing just that.

[Interviewer:] So the law itself establishes that these associations have this role?

Well, it has been agreed between CatSalut and these associations. The instruction [10/2012] simply says that these people without papers will be attended, that's what CatSalut says [...], but then, the procedure of how we apply this is now that these associations are doing it (bcn-A08).

It is important to emphasise that here, 'without papers' refers to the *lack* of a patient's identification, not the '*illegality*' of his or her residence, which *per se* does not hinder their inclusion into the mainstream system, as the same interviewee later clarifies:

For me, the *undocumented* are those who come by boat [*'patera'*] with what they have on them, with no identification or anything, and these come through the associations. But those who came by plane [i.e. on a tourist visa, which they overstayed] and have a passport... I attend them and process their application without any problem (bcn-A08).

Her perception is supported by a qualitative study carried out by the Public Health Agency of Barcelona, which found no significant difference between the self-reported experiences when accessing healthcare between regular and irregular migrants (Agència de Salut Pública de Barcelona, 2011). The 'Platform for Universal Health Care in Catalonia', an umbrella group of health professionals and NGOs dedicated to documenting the 'often arbitrary application of the new health regulations in Catalonia', found 72 cases of arbitrary exclusion of migrants, of which more than half (54%), however, were lawful residents (PASUCAT, 2014).

In order to register with a GP practice in London – as in the rest of the UK, where no general system of residential registration exists – applicants have to provide other forms

of ‘proof of address’, usually a tenancy agreement, utility bill or bank statement in the name of the applicant⁵. While practices have an obligation to provide emergency and immediately necessary treatment to any person within the practice area, they can exercise some degree of discretion about whether or not to register a person; or to treat them privately, i.e. as self-paying patients (da Lomba, 2011). Importantly, other than in Catalonia there is no specific legislation regulating the provision of primary care to Overseas Visitors or establishing a minimum period of prior residence, so that persons staying in the country for less than three months may either be registered as ‘temporary residents’ or be included in the regular patients list (Department of Health, 2012). GPs can refuse a patient on reasonable, non-discriminatory grounds – for example, because they live outside the catchment area⁶ – or if their list is full (Aspinall, 2014; Wind-Cowie & Wood, 2014). Even regarding the widespread practice of requiring personal identification at registration, the British Medical Association (BMA) advises practice staff, that ‘[o]verseas visitors have no formal obligation to prove their identity or immigration status to register with a practice’⁷. According to Doctors of the World (DOTW, 2013), however, over two thirds of London’s Primary Care Trusts (PCTs) have issued guidance that is incompatible with GPs’ legal obligations; for example, by advising them to only register people living lawfully in the UK for more than six months. While in fact this ‘ordinary residence’ criteria only applies to secondary care, it is sometimes extended to primary care, as the account of one GP I interviewed in South-East London reveals:

It’s true that we have a very good system that is free at the point of delivery, but you still have to have an NHS number. That means that you would need to be a resident in the UK for at least 6 months in a year. [...] If, for example, you are visiting for a short time, you do have to pay even to see a GP. [...] So... I mean, sometimes we do try and help as much as possible, [...] but it depends, of course. It’s different from one doctor to another, from one surgery to another, even in primary care. I mean I personally would like to ... to do that ... I mean, I’d probably try and help patients to get

⁵ Alternatively, other official letters, telephone bills, etc. stating the name and address are usually accepted.

⁶ Since 5 January 2015, GP practices in England are free to register new patients who live outside their practice boundary area (see: <http://www.nhs.uk/nhsengland/aboutnhservices/doctors/pages/patient-choice-gp-practices.aspx>) which means that they don’t necessarily *have to* ask for proof of address.

⁷ See: BMA guidelines on overseas visitors and primary care: <http://bma.org.uk/practical-support-at-work/gp-practices> (24/4/15).

[registered], even though sometimes they are not eligible, so it's probably not right... but... it's difficult. I think it's sometimes the right thing to do. It's for the best interest of the patient (lon-A25).

The Department of Health (2012) also acknowledges that – in contradiction to current rules – ‘some practices have deregistered or failed to register people they believe to be ‘ineligible’ in some way due to their immigration status’. Other practices are well aware of the problem and deliberately exercise explicitly liberal access policies, as the head receptionist of a GP practice in Hackney is keen to emphasize:

No, we don't check people's passports, we don't check if people are allowed [to stay] 6, 7 or 8 months according to the stamp of their passport, or how they got here... that is not something we police at our health centre. We don't police the service that we provide to people. Others do, but we don't (lon-A14).

At the same time, she also recognises that what she describes as ‘our doctors’ decision’ – to not (anymore) verify the patients’ identity or even address – sometimes creates more work for reception staff (for example, due to multiple registrations) and makes it more difficult to deliver follow-up treatment.

Ultimately, these accounts also highlight the crucial role of individual discretion and its increasing intersection with immigration regulations: On the one hand, the ambiguous concept of ‘emergency’ ‘gives considerable discretionary power to health professionals by letting them decide whether some types of care should be considered as “emergency care” or not’ (DOTW, 2013, p. 41; OHCHR, 2014). The responsible doctor at one CAP in Barcelona's central district *Ciutat Vella* (quite proudly) maintains that this allows him to basically treat everyone, without breaking the law:

We [as doctors] can decide that. And so that opens a door for us to make different exceptions when we think it is appropriate from a medical point of view. [...] According to the law you can treat any urgent [case], someone that you consider is an urgent case. And I can consider that everything that comes through the door is an urgent case (bcn-A14).

On the other hand, and this is particularly true for the UK context, there is a tendency of healthcare staff increasingly being expected to form part of the state's efforts to police

immigration rules. Especially GPs, as the main ‘gatekeepers’ of the NHS system⁸, are thereby put in a difficult position:

If that happens – because there has been also talk about that we should be one of the first...well...to put barriers, and we should actually identify people⁹ – it can be difficult with confidentiality. If for example, someone comes in and they are an illegal immigrant and I see them as an emergency and they say ‘oh please don’t say I am [irregular]’... then this is... I don’t know what to do in that situation. I wouldn’t know (GP, lon-A25, 2).

In the UK in particular, negative media and public discourses focusing on ‘health tourism’ and/or the need to discourage ‘illegal’ immigration by all possible means threaten to not only undermine legal entitlements and individual doctors’ duty of care (DOTW, 2013), but also jeopardise confidentiality and trust, which are essential to the doctor-patient relationship and necessary for a correct diagnosis and successful treatment (Kilner, 2014; Wind-Cowie & Wood, 2014). It is here that a major difference between the two cases becomes apparent: While in both contexts studied, access to free primary healthcare formally includes (or at least not excludes) irregular migrants, in Catalonia this is done through a much more explicit legal framework and a specific administrative procedure. Both imply and reflect a political *decision* through which politicians formally *justify* the necessary inclusion of these local residents. This arguably reduces the pressure on individual providers and administrators of care, as the following accounts of a receptionist and a family doctor of another CAP of *Ciutat Vella* suggest:

It is simpler for us [to register a person with regular papers] because it is very automatic and easier to introduce them [into the system]. But well, now that we have this type of health card [for persons in irregular situations], which we didn’t have before, also in their case – once they fulfil the requirements – we automatically put them on, we assign them a doctor, give them appointments, etc. (bcn-A13).

⁸ The UK Dept. of Health (2010, p. 27) recognises the ‘the crucial role that GPs already play in committing NHS resources through their daily clinical decisions – not only in terms of referrals and prescribing, but also how well they manage long-term conditions, and the accessibility of their services’.

⁹ What she refers to is the Dept. of Health’s (2013a, p. 52) suggestion that GPs – as well as A&E staff – may ‘identify in the referral letter any patient whom they believe may be an overseas visitor, which the relevant NHS body could then check’.

Look, for me they simply appear on the list of patients that I am going to see on that day, whether in a regular consultation or as an urgent case [...] So this patient, who in principle is in an irregular situation, appears on my list, and I don't question anything (bcn-A12).

In the UK in contrast, irregular migrants accessing NHS care always constitute 'an exception to the rule that makes eligibility contingent on lawful residence' (da Lomba, 2011, p. 363), which means that, in the words of a London-based health advocate,

[...] there isn't a system here that you have to go through and get a certificate from somewhere which you then take to the hospital, so either you are in, and anybody *can* be in, or you are not in. But there is confusion about who is in and who is not in, and that's the difficulty (lon-A08).

Some of the resulting difficulties regarding the inclusion of irregular residents as well as the differences in the formal rules and regulations between the two cases compared become even more pronounced when looking at the level of secondary care.

3.2 Irregular migrants' access to secondary healthcare

While in practice, primary and secondary care are closely linked – through internal referral systems, etc. – access to the latter implies much higher costs to the healthcare system and is therefore subjected to stricter rules and controls. According to the legal framework established in Catalonia in 2012, migrants in irregular situations were only given normalised access to secondary care after a continuous residence of one year, while any specialised treatment required before that had to be authorised, on a case-by-case basis, by a special commission within *CatSalut*, as the Citizen Relations Manager explained to me in June 2015:

The so-called *Commission of Exceptional Access to Programmed Specialised Care* was created to deal with those cases [of patients] that did not have access to specialised care but because of their illness had to be treated; and [of those] we have had 60 or 70 cases a year... that is, there are very few people who are asking us [...] to be treated or admitted to a hospital during that first year. [...]

[Interviewer:] And what is the decision of this commission based on, then?

The decision is based on a clinical report issued by a hospital, saying 'this person with this diagnosis would have to be provided access to specialized care'. And so there is this Commission formed by a jurist, a purchasing specialist, a hospital doctor, a member of the citizen relations department, and there is also a pharmacist... and between these professionals they analyse the case and then say yes or no. Basically in all the cases presented - I think that 99% - they said yes (bcn-A17).

Only one of the health centre receptionists I interviewed remembered 'one or two non-urgent cases', where they had suggested their patients to wait until they fulfilled the one-year residence requirement (bcn-A08). While from the perspective of *CatSalut*, upholding this temporary distinction between 'irregular' and 'normal' patients thus seemed to create both extra work and unnecessary delays, *Medicos del Mundo* (MdM, 2014) had criticised the absence of transparent criteria to be applied by the commission when determining each individual case. Together with the constant pressure of professional associations such as PASUCAT, this led the government to abolish the one year waiting period in July 2015, through instruction 8/2015, thus giving irregular migrants access to the full range of publically funded services after only three months of (proven) residence (Blay, 2015).

In the UK, on the contrary, since 2004 all foreigners who are not 'ordinarily resident' – which is not explicitly defined in law but is conditional, among other things, on lawful residence – are considered Overseas Visitors and thus, in principle, have to pay for NHS hospital treatment¹⁰ (Aspinall, 2014; da Lomba, 2011; Department of Health, 2013a). Any treatment that is considered 'urgent' or 'immediately necessary' cannot 'be delayed or withheld pending payment', but Overseas Visitors will be charged the full cost (Department of Health, 2013b, p. 55). As noted before, the discretion in taking these decisions – since always based on a *medical* assessment of the patient's condition – comes with the very nature of the doctor's profession and thus necessarily plays a significant role within every healthcare system (semFYC, 2012). In the case of the UK,

¹⁰ Until 2004, like in Catalonia between 2012 and 2015, they were entitled to free treatment after 12 months of, even irregular, residence in the country. Exceptions from the general charging regulations are in place for certain cases, such as the diagnosis and treatment of a regularly updated list of communicable diseases.

however, where treatment offered to Overseas Visitors is defined as ‘urgent’ where it ‘cannot wait until the person can be reasonably expected to return home’ (Department of Health, 2013a, p. 43), clinicians are required to take into consideration the likelihood (and possible duration) of a patient’s stay in the country (da Lomba, 2011). Both directly depend on his or her immigration status and are particularly difficult to assess in the case of irregular migrants, who are estimated to represent more than 60% of the ‘chargeable population’ (Department of Health, 2012, 2013a).

The UK Department of Health (2013b, p. 13) emphasises that *all* ‘[r]esidency based, tax-funded systems rely on the identification of those who are not entitled rather than those who are, with the onus on staff to identify those who should be charged.’ While in the case of Catalonia the level of entitlement (depending, among other things, on income and employment status) is clearly indicated on every patient’s personal health card, Overseas Visitors in the UK, once registered with a GP, will hold the same NHS card as any other NHS patient, lacking any indication of the holder’s entitlement beyond primary and emergency care. Notably, this remainder of the system’s universal origins has created the need for specific administrative personnel – the so-called ‘Overseas Visitors Manager’ (OVM) – who are responsible for fulfilling every NHS hospital’s legal obligation ‘to determine whether the Charging Regulations apply to any overseas visitor they treat’ (Department of Health, 2013a, p. 16). During my interview with the OVM of a London hospital, my interviewee received a phone call from the hospital’s maternity ward notifying her about the arrival of a new patient. Afterwards she explained:

In that case I would be very very surprised if that person is entitled to NHS care. So we will go up to see her, we will ask her to see her documentation. I mean she is on the labour ward so I don’t think that’s the right time to ask, personally, so I will probably leave that and go after she has given birth. We will ask to see her documentation, we will ask her relatives to bring in that documentation. It could be that she has got leave to remain. It may have been that she just came to see her family and just came down... you know, we cannot guarantee that. But that case we would class as suspicious (lon-A09).

This is a good example of how ‘NHS staff often have to make assumptions about

government policy in their work', as Wind-Cowie and Wood (2014, p. 55) have noted. Asked what will happen in case the patient is not able to prove her entitlement, or even to produce a valid passport, my interviewee replied:

That's right, they have to produce their passport, which [...] will have a stamp in it, so that will show whether that person is entitled or not. From there, once we have identified her, we will raise an invoice. If she doesn't pay... again: we have to treat this patient, but if she doesn't pay, then in three months time that invoice will be going over to... we will inform the Department of Health (lon-A09).

This is where the incentive of NHS hospitals to recover the costs for often very expensive treatments significantly overlaps with the efforts of immigration authorities to detect irregular migrants or at least deter their use of public services. According to the rules, once identified as an Overseas Visitor, the full costs have to be borne by the patient and – if not paid – remain with the hospital. While this creates a significant incentive to require payment in advance and otherwise deny treatment (where it is not considered 'urgent'), an official review of this policy also points to a lack of incentive to properly identify chargeable patients in the first place (Department of Health, 2012). While the efficiency of this system thus depends a lot on individual OVMs doing their job well, the proximity between healthcare and immigration policy becomes most explicit through a formal mechanism, whereby

NHS bodies (or debt collection agencies working on their behalf) can share non-medical information with the Home Office, via the Department of Health, on those with a debt of £1,000 or more once that debt has been outstanding for three months, with a view to better collect debts owed. The Home Office can then use that information to deny any future immigration application to enter or remain in the UK that the person with the debt might make (Department of Health, 2013a, p. 63).

Notably, this information exchange does not require patients' consent although they *should* be made 'aware of the potential immigration consequences of not paying' (*ibid.*), which for Wind-Cowie and Wood (2014, p. 13) 'poses an enormous ethical challenge for healthcare professionals and the NHS as a whole'. A maternity health advocate interviewed in Hackney describes this dilemma from the perspective of a midwife:

Should she say ‘I will treat you because you are entitled to maternity care, but I have to tell you that you will be billed, and if you can’t pay the bill, that information will be sent to the Home Office’? I mean, I don’t know what I would do if I was a midwife, but that would be the correct information (lon-A08).

This again stands in stark contrast to the situation in Catalonia, but also the rest of Spain, where the unconditional entitlement of all minor children and pregnant women to free healthcare was left untouched by the 2012 health reform. The UK Department of Health (2013b, p. 17) is aware of the inherent problem, noting that ‘[c]linicians are not expected to take on the role of immigration officials, but they are often well placed to identify visitors who are chargeable’. However, as long as immigration status is the main criterion for charging, NHS staff – even if not clinicians themselves – will effectively be playing a role in controlling immigration. The account of the above-cited OVM – asked how she felt about *quasi* acting as an immigration officer – clearly reveals these ambiguities:

I don’t think we do. I mean, if you were an immigration officer you would be informing immigration [authorities], you would be informing the borders agency. And we will work with the borders agency, and we will let the ... the Department of Health know of patients that owe us money. Now: it’s the Department of Health that then would possibly pass that information to the Home Office, and it would, you know, then put it on a system so that perhaps these people... but they are not traced here! It’s normally the people that try to get back [into the UK] that we are stopping. [...] So personally I don’t think that we work as an immigration officer, ... maybe wrongly. Perhaps we do (lon-A09).

This mechanism, as well as recent media reports about the Home Office routinely ‘accessing NHS records to help track down illegal immigrants’ (Ball, 2014), strikingly highlight the lack of what numerous human rights bodies and NGOs call an ‘effective firewall’ between the state’s health services and its immigration enforcement agencies (FRA, 2013; OHCHR, 2014). Lucy Jones of DOTW says that ‘at the moment [...] we feel fairly confident that accessing healthcare won’t result in immigration enforcement action against undocumented migrants, but increasingly that is a concern’ (lon-A03).

Health advocates, professionals and NGO workers interviewed in Barcelona, on the other hand, have all made very clear that public services play no part in immigration control or even enforcement. It is important, however, to distinguish between the behaviour of individuals and the role of (public) institutions as such, as Imma Mata, head of the area of immigration within *Caritas Barcelona*, pointed out:

It is true that going to social services or to the doctor you can find racist people, or people who are against immigrants, and so a migrant can [be treated wrongly]. But this is an individual issue [...] it is not that the educational or sanitary institutions, or social services, would carry out controls for the police, or for the ministry of the interior, no. It doesn't exist and nobody would defend that or say that it should exist.

The comparison of the two cases suggests that while the nature of healthcare always leaves significant scope for individual discretion – which in theory could have exclusionary as well as inclusionary effects – this discretion becomes most problematic where it is not (just) to be based on medical indications but instead systematically intersects with the (il)legality of a patient's residence within a given state.

4. Conclusion

The question of whether or not, or even to which exact extent irregular migrants should be given access to free public healthcare poses a challenge to contemporary welfare states. Providing these services to unlawful residents undermines the very idea that their presence and claims are fully illegitimate and instead reflects their recognition, by the state, as *de facto* members of society (even if not the nation itself). Restricting their access, on the other hand, whether by denying registration, charging the costs or involving immigration enforcement, not only tends to breach fundamental human rights obligations but also gives rise to serious public health concerns. In this sense, the presence of irregular migrants brings two functional imperatives of the state in direct opposition: the control of immigration and the provision of healthcare to its population. The formal reconciliation of any such opposition hinges on a *political* decision that gives preference to one over the other (in any particular case), and thereby forms the basis for the legal framework within which the relevant actors should act. For the

resulting laws and regulations to be effective, however, they must not be in conflict with the guiding principles and function of the institutions made responsible for their implementation, or require the individual actors working within these to comply with (or break) a law that they perceive as contrary to their profession. Whatever the decision, it should not keep them from *doing their job*, as the receptionist of a health centre put it:

They [the politicians] are the ones telling us how we must [do our] work, in principle, no? This is to say, the system functions a bit according to what they tell us. But OK, then we know for ourselves how we can mould it [*moldearlo*]. We are part of this as well, but ... of course, sometimes they put us a lot of obstacles to be able to do our best possible work, no? Sometimes we would like to do more but it's not possible, because they don't let us (bcn-A13).

In this article, I have looked at this issue through the theoretical lens provided by Brunsson's (1993) conceptualisation of two alternative relationships between the ideas of constituencies or 'leaders', and (a particular kind of) organisational action that the former cannot simply *control* without regard to its inherent functional and operational logics. What they can do instead, is to either adjust their decisions (or even the underlying ideas) to become (more) compatible with these logics: *justification*; or establish and defend a set of rules that is ambiguous enough to serve contradictory aims: *hypocrisy*. Seen from the perspective of individual actors, the former helps them to *do their job*, while the latter puts them in the difficult position of having to manage the underlying moral and political conflict by themselves and often on a case-by-case basis.

Comparing the distinct ways in which the governments of the UK, Spain and Catalonia have been managing the local provision of public healthcare to irregular migrants I have identified several elements of both *justification* and *hypocrisy*. In the UK, where the government's official approach to create a 'hostile environment' for irregular migration has led the logic of immigration control to increasingly determine more and more areas of social policy (including housing, education and health) while chances for regularisation are slim, politicians find it difficult to openly justify any *inclusion* of irregular migrants. The way their access to healthcare is managed, both politically and in practice, thus very well resembles what Brunsson calls *hypocrisy*: The state's

overarching aim of preventing any ‘illegitimate’ use of public services is not only reflected in the severe restrictions and control of irregular migrants’ access to NHS hospital care, but also in the absence of legislation specifying the entitlements they *do* have as local residents, i.e. to receive free primary care. The latter makes even this fundamental right less visible – arguably both for the migrants themselves (to discourage them from accessing) as well as the indigenous citizenry (to avoid an anti-immigrant backlash) – and more difficult to assert. Since they cannot be completely excluded, however, these entitlements are administratively blurred by placing irregular residents in the same category (‘Overseas Visitors’) as suspected ‘health tourists’, although they clearly face a very distinct reality (Wind-Cowie & Wood, 2014). Defined as such, they are to be identified and charged – by the hospital – even for medically necessary treatment such as maternity services, and are thus exposed to a well-founded fear that accessing the care they need may jeopardise their stay in the country. In this light, the restrictive healthcare reform in Spain, but also the announcement of the Spanish Health minister – to restore irregular migrants’ access to primary care while explicitly denying them a health card – also appear as a way of deliberately *not including* them into the mainstream system.

While both national governments at least rhetorically give preference to immigration control, the government of Catalonia – which has no competence in that field but is responsible for the local provision of healthcare – has deliberately given preference to public health. In open contradiction to national legislation it established an explicit legal framework and administrative procedure that allows for the progressive inclusion of irregular *residents* into the mainstream system, while (non-resident) ‘health tourists’ are to be charged. Through this decision it thus officially *justifies* irregular migrants being treated as ‘legitimate’ recipients of the services provided by *CatSalut*, thereby absolving healthcare workers and institutions from any responsibility to enforce immigration rules or even inquire a patient’s administrative status. At the same time, however, the procedure requires applicants to approach (usually in person) various public institutions, including the National Institute for Social Security (which certifies the lack of national health coverage) and the City Council (in order to register as a local resident). Obviously, such a system can only work in practice if none of these institutions is linked to immigration enforcement and within an environment that is *not* perceived as generally hostile towards irregular migrants. Instead, it ultimately requires a certain

acceptance of irregular migration and residence as part of the country's social reality, and thus an issue to be *accommodated* across the various areas of public policy. In the UK in contrast, migrant irregularity is instead portrayed and treated as an issue that must (and actually can) be *prevented* through the extension of immigration control into many of these areas, including healthcare. The role of the 'Overseas Visitors Manager' – responsible for implementing not only the charging regime but also the government's 'hostile environment' approach within NHS hospitals – most strikingly illustrates this gradual shift of responsibilities (and costs) of border control to the healthcare system.

Bibliography

Aasen, H. S., Kjelleevold, A., & Stephens, P. (2014). 'Undocumented' migrants' access to health care services in Europe: tensions between international human rights, national law and professional ethics. In H. S. Aasen, S. Gloppen, A.-M. Magnussen, & E. Nilssen (Eds.), *Juridification and social citizenship in the welfare state* (pp. 162–182). Edward Elgar Publishing, Incorporated.

Agència de Salut Pública de Barcelona. (2011). *Immigració i serveis sanitaris a la ciutat de Barcelona. La perspectiva de la població marroquina, xinesa, equatoriana i pakistanesa*. Barcelona.

Ajuntament de Barcelona. (2013). Documento informativo sobre: Nueva directiva para el acceso al sistema público de salud. Barcelona.

Ambrosini, M. (2015). NGOs and Health Services for Irregular Immigrants in Italy: When the Protection of Human Rights Challenges the Laws. *Journal of Immigrant & Refugee Studies*, 13(2), 116–134. doi:10.1080/15562948.2015.1017631

Aspinall, P. (2014). *Inclusive Practice. Vulnerable Migrants, Gypsies and Travellers, People Who Are Homeless, and Sex Workers: A Review and Synthesis of Interventions/Service Models that Improve Access to Primary Care & Reduce Risk of Avoidable Admission to Hospital*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305912/Inclusive_Practice.pdf

Ball, J. (2014). Home Office accessing NHS records to help track down illegal immigrants. *The Guardian*. Retrieved from <http://www.theguardian.com/uk-news/2014/jul/13/home-office-nhs-records-illegal-immigrants>

Blay, B. (2015). El Govern abre las puertas de la sanidad pública a colectivos que quedaban excluidos. *El Diario*. Retrieved from http://www.eldiario.es/catalunya/diarisanitat/Govern-sanidad-colectivos-quedaban-excluidos_6_412318790.html

Boswell, C. (2007). Theorizing Migration Policy: Is There a Third Way? *International*

Migration Review, 41(1), 75–100. doi:10.1111/j.1747-7379.2007.00057.x

Broeders, D., & Engbersen, G. (2007). The Fight Against Illegal Migration: Identification Policies and Immigrants' Counterstrategies. *American Behavioral Scientist*, 50, 1592–1609. doi:10.1177/0002764207302470

Brunsson, N. (1989). The Organization of Hypocrisy : Talk, decisions and actions in organizations. John Wiley & Sons. Retrieved from <http://www.diva-portal.org/smash/record.jsf?pid=diva2%3A358205&dswid=-9068>

Brunsson, N. (1993). Ideas and actions: Justification and hypocrisy as alternatives to control. *Accounting, Organizations and Society*, 18(6), 489–506. doi:10.1016/0361-3682(93)90001-M

Castles, S. (2004). Why migration policies fail. *Ethnic and Racial Studies*, 27(2), 205–227. doi:10.1080/0141987042000177306

Chauvin, S., & Garcés-Mascreñas, B. (2012). Beyond informal citizenship: The new moral economy of migrant illegality. *International Political Sociology*, 6(3), 241–259. doi:10.1111/j.1749-5687.2012.00162.x

Cornelius, W. A., Martin, P. L., & Hollifield, J. F. (1994). Introduction: The Ambivalent Quest for Immigration Control. In W. A. Cornelius, P. L. Martin, & J. F. Hollifield (Eds.), *Controlling Immigration: A Global Perspective* (First edit., pp. 3–41). Stanford: Stanford University Press. Retrieved from https://books.google.co.uk/books/about/Controlling_Immigration.html?id=xJkyMwYnXocC&pgis=1

Cvajner, M., & Sciortino, G. (2010). Theorizing Irregular Migration: The Control of Spatial Mobility in Differentiated Societies. *European Journal of Social Theory*, 13(3), 389–404. doi:10.1177/1368431010371764

da Lomba, S. (2011). Irregular migrants and the human right to health care: a case-study of health-care provision for irregular migrants in France and the UK. *International Journal of Law in Context*, 7(3), 357–374. doi:10.1017/S1744552311000188

De Genova, N. (2013). Spectacles of migrant “illegality”: the scene of exclusion, the obscene of inclusion. *Ethnic and Racial Studies*, 36(7), 1180–1198. doi:10.1080/01419870.2013.783710

Department of Health. (2010). Equity and excellence: Liberating the NHS.

Department of Health. (2012). 2012 Review of Overseas Visitors Charging Policy. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210439/Overseas_Visitors_Charging_Review_2012_-_Summary_document.pdf

Department of Health. (2013a). Guidance on implementing the overseas visitors hospital charging regulations. Retrieved from <https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations>

Department of Health. (2013b). Sustaining services, ensuring fairness. A consultation on migrant access and their financial contribution to NHS provision in England.

Deutsch, K. (1970). *Politics and Government: How People Decide Their Fate*. Boston:

Huffington Mifflin.

DOTW. (2013). *Access to Healthcare in Europe in times of crisis and rising xenophobia*.

Dwyer, J. (2015). On Taking Responsibility for Undocumented Migrants. *Public Health Ethics*, 8(2), 139–147. doi:10.1093/phe/phv005

El Gobierno anuncia que devolverá parte de la atención sanitaria a los inmigrantes sin papeles. (2015). *El Diario*. Madrid. Retrieved from http://www.eldiario.es/sociedad/inmigrantes-irregulares-volveran-atencion-primaria_0_372362835.html

FRA. (2013). *Apprehension of migrants in an irregular situation – fundamental rights considerations*.

FRA. (2015). *Cost of exclusion from healthcare – The case of migrants in an irregular situation*. Retrieved from <http://fra.europa.eu/en/publication/2015/cost-exclusion-healthcare-case-migrants-irregular-situation>

Freeman, G. P. (1995). Modes of Immigration Politics in Liberal Democratic States. *International Migration Review*, 29(4), 881–902. doi:10.2307/2547729

Grove-White, R. (2014). Immigration Act 2014: what next for migrants' access to NHS care? *Migrants' Rights Network Blog*. Retrieved from <http://www.migrantsrights.org.uk/blog/2014/05/immigration-act-2014-what-next-migrants-access-nhs-care>

Guiraudon, V. (2003). The constitution of a European immigration policy domain: a political sociology approach. *Journal of European Public Policy*, 10(2), 263–282. doi:10.1080/1350176032000059035

Hall, M. A., & Perrin, J. (2015). Irregular Migrant Access to Care: Mapping Public Policy Rationales. *Public Health Ethics*, 8(2), 130–138. doi:10.1093/phe/phv016

Hollifield, J. F. (1986). Immigration Policy in France and Germany: Outputs versus Outcomes. *The Annals of the American Academy of Political and Social Science*, 485, 113–128. Retrieved from <http://www.jstor.org/stable/1045445>

House of Commons. (2013). Immigration Bill, Public Bill Committee, Tuesday 12 November. Retrieved from <http://www.publications.parliament.uk/pa/cm201314/cmpublic/immigration/131112/am/131112s01.htm#13111257000035>

Isin, E. F. (2008). Theorizing Acts of Citizenship. In Engin F. Isin and Greg M. Nielsen (Ed.), *Acts of Citizenship* (pp. 15–43). doi:10.1016/B978-0-7020-2797-0.00001-1

Johnson, W. (2012, April 11). Boris Johnson criticised over medical guide for migrants. *The Independent*. Retrieved from <http://www.independent.co.uk/news/uk/politics/boris-johnson-criticised-over-medical-guide-for-migrants-7636287.html>

Joppke, C. (1998). Why Liberal States Accept Unwanted Immigration. *World Politics*, 50(2), 266–293. doi:10.2307/25054038

Kilner, H. (2014). Hostile health care: why charging migrants will harm the most vulnerable. *The British Journal of General Practice : The Journal of the Royal College of General Practitioners*, 64(626), e590–2. doi:10.3399/bjgp14X681565

- Kirkup, J., & Winnett, R. (2012). Theresa May interview: 'We're going to give illegal migrants a really hostile reception'. *The Telegraph*. Retrieved from <http://www.telegraph.co.uk/news/uknews/immigration/9291483/Theresa-May-interview-Were-going-to-give-illegal-migrants-a-really-hostile-reception.html>
- Kraler, A. (2011). Fixing, Adjusting, Regulating, Protecting Human Rights - The Shifting Uses of Regularisations in the European Union. *European Journal of Migration and Law*, 13, 297–316.
- Lahav, G., & Guiraudon, V. (2006). Actors and venues in immigration control: Closing the gap between political demands and policy outcomes. *West European Politics*, 29(2), 201–223. doi:10.1080/01402380500512551
- Legido-Quigley, H., Urdaneta, E., Gonzalez, A., La Parra, D., Muntaner, C., Alvarez-Dardet, C., ... McKee, M. (2013). Erosion of universal health coverage in Spain. *The Lancet*, 382(9909), 1977. doi:[http://dx.doi.org/10.1016/S0140-6736\(13\)62649-5](http://dx.doi.org/10.1016/S0140-6736(13)62649-5)
- Mayor of London. (2012). How can I get medical help in London? Retrieved from <http://www.london.gov.uk/publication/access-to-health>
- MdM. (2014). *Dos años de reforma sanitaria: más vidas humanas en riesgo*. Retrieved from http://www.medicosdelmundo.org/index.php/mod.documentos/mem.descargar/fichero.documentos_Impacto-Reforma-Sanitaria-Medicos-del-Mundo_3ec0bdf9#2E#pdf
- Mezzadra, S. (2011). The Gaze of Autonomy: Capitalism, Migration and Social Struggles. In V. Squire (Ed.), *The contested politics of mobility. Borderzones and irregularity* (pp. 121–142). London: Routledge.
- OHCHR. (2014). *The economic, social and cultural rights of migrants in an irregular situation*. New York and Geneva.
- PASUCAT. (2014). *Dos anys des del canvi de model sanitari. Dos anys d'exclusió*. Retrieved from <https://docs.google.com/file/d/0B2opi6SzvyEKTXRxTWtLTjIjXNmc/edit>
- PICUM. (2009). *Undocumented and Seriously Ill: Residence Permits for Medical Reasons in Europe*. Retrieved from http://picum.org/picum.org/uploads/publication/Undocumented_and_Seriously_Ill_Report_Picum.pdf
- Sassen, S. (1996). *Losing Control?: Sovereignty in an Age of Globalization*. Columbia University Press. Retrieved from <https://books.google.com/books?id=bDT75tjeHeUC&pgis=1>
- semFYC. (2012). *Analysis ético ante la retirada de la asistencia sanitaria a inmigrantes sin permiso de residencia*. Retrieved from http://www.semfy.com/pfw_files/cma/noticias/noticia/analisis_etico_retirada_asistencia_sanitaria.pdf
- Soysal, Y. N. (1994). *Limits of Citizenship. Migrants and Postnational Membership in Europe*. University of Chicago Press.
- Spencer, S. (2014). The Sunshine and Shadow Politics of Irregular Migrants in Europe. In B. Anderson & M. Keith (Eds.), *Migration: A COMPAS Anthology*. COMPAS Oxford. Retrieved from <http://compasanthology.co.uk/sunshine-shadow-politics->

irregular-migrants-europe/

Steele, S., Stuckler, D., McKee, M., & Pollock, A. M. (2014). The Immigration Bill: extending charging regimes and scapegoating the vulnerable will pose risks to public health. *Journal of the Royal Society of Medicine*, 107(4), 132–3. doi:10.1177/0141076814526132

Van Der Leun, J. (2006). Excluding illegal migrants in The Netherlands: Between national policies and local implementation. *West European Politics*, 29(2), 310–326. doi:10.1080/01402380500512650

Walsh, J. P. (2014). Watchful Citizens: Immigration Control, Surveillance and Societal Participation. *Social & Legal Studies*, 23(2), 237–259. doi:10.1177/0964663913519286

Webber, F. (2014). Extending immigration policing and exclusion in the UK. *Race & Class*, 55(3), 86–92. doi:10.1177/0306396813509199

Wind-Cowie, M., & Wood, C. (2014). *Do no Harm. Ensuring fair use of the NHS efficiently and effectively*. London. Retrieved from http://demos.co.uk/files/Demos_DoNoHarmREPORT.pdf?1413823102